Death Report Form to DHHS

This form is used to report deaths for state facilities operating in accordance with G.S. 122C Article 4, Part 5, psychiatric hospitals licensed under G.S. 122C, and inpatient psychiatric units licensed under G.S. 131E. ■ This form may also be used to report deaths pursuant to 42 CFR 482.13(f)(7). ■ All deaths related to use of seclusion or restraint, accidents, homicides, suicides or violence must be reported. Please provide an explanation for any requested information that is unavailable. ■ If additional space is needed, attach separate sheets, referencing the part of the form to which the information pertains. ■ Additional information that is considered relevant, such as client assessments and discharge summaries, may be included. ■ Please keep a copy of the report for your records.

Send or fax form to: Complaint Intake Unit, 2711 Mail Service Center, Raleigh, NC 27699-2711. Fax: 919-715-7724. Phone: 800-624-3004

Section 1: Reporting Facility

Name of reporting facility	Address:	
Medicare/Medicaid Provider # (if applicable):	License # (if applicable):	County:
Facility Director:	Telephone:	
First Person to Discover Decedent:	Staff first receiving report of decedent's death:	
Person/Title Preparing Report:	Date/Time Report Prepared	

Section 2: Client Information

Name of Decedent:	Client Record #:	Unit/Ward (if applicable):	
	Medicare/Medicaid #:	Date of Birth:	Age:
Admitting Diagnoses:	Adjudicated incompetent: ☐ **Yes** ☐ **No**	Weight (if known):	Race:
	Date(s) of last two (2) medical exams (if known):	Height (if known):	Sex:
Date of most recent admission to a State operated psychiatric developmental disability or substance abuse facility (if known):	Date of most recent admission to an acute care hospital for physical illness (if known):		
Primary/secondary mental illness, developmental disability, or substance abuse diagnosis:			
Primary/secondary physical illness/conditions diagnosed prior to death:			

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Section 3: Circumstances of Death

Place where decedent died:	Date and time death was discovered:
Address:	Physical location decedent was found:
	Cause of death (if known):
Was decedent "restrained" at the time of death or within 7 days of death? ☐ **Yes** ☐ **No**	Was decedent in "seclusion" at the time of death or within 7 days of death? ☐ **Yes** ☐ **No**
Describe events surrounding the death:	

Section 4: Other Information

Please list other authorities (such as law enforcement or the County Department of Social Services) that have been notified, have investigated or are in the process of investigating the death or events related to the death: